## DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 09/01/2011 FORM APPROVED OMB NO. 0938-0391

| CENTERS FOI  | R MEDICARE & MEDIC                | CAID SERVICES                  |                                     |             |   | ON      | IB NO. 0938-0391 |
|--|-----------------------------------|--------------------------------|-------------------------------------|-------------|---|---------|------------------|
| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA |                                   | (X2) M                         | ULTIPLE CO                          | ONSTRUCTION | (X3) DATE   | SURVEY  |                  |
| AND PLAN OF CORRECTION IDENTIFICATION NUMBER:        |                                   | IDENTIFICATION NUMBER:         | A. BUILDING 00                      |             | 00  | COMPI   | LETED            |
| 151306   |                                   |                                | B. WING                             |             |   | 07/19/2 | 2011             |
|  |                                   |                                | B. WIN                              |             | ADDRESS, CITY, STATE, ZIP CODE  |         |                  |
| NAME OF PROVIDER OR SUPPLIER                         |                                   |                                |                                     |             |   |         |                  |
|  |                                   |                                | 642 W HOSPITAL RD<br>PAOLI, IN47454 |             |   |         |                  |
| INDIANA UNIVERSITY HEALTH PAOLI HOSPITAL             |                                   |                                |                                     |             |   |         |                  |
| (X4) ID  | SUMMARY STATEMENT OF DEFICIENCIES |                                |                                     | ID          | PROVIDER'S PLAN OF CORRECTION   | (X5)    |                  |
| PREFIX   | (EACH DEFICIE)                    | NCY MUST BE PERCEDED BY FULL   | PREFIX                              |             | (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE |         | COMPLETION       |
| TAG  | REGULATORY OF                     | R LSC IDENTIFYING INFORMATION) |                                     | TAG         | DEFICIENCY)   |         | DATE             |
| S0000  |                                   |                                |                                     |             |   |         |                  |
|  |                                   |                                |                                     |             |   |         | 1                |
|  | This visit was fo                 | or a State licensure survey.   | S0                                  | 000         |   |         |                  |
|  |                                   |                                |                                     |             |   |         |                  |
|  | Facility Number                   | r: 005065                      |                                     |             |   |         |                  |
|  |                                   |                                |                                     |             |   |         |                  |
|  | Dates: 7-18-11                    | through 7-19-11                |                                     |             |   |         |                  |
|  | Dates. 7-10-11                    | unougn /-19-11                 |                                     |             |   |         |                  |
|  | G                                 |                                |                                     |             |   |         |                  |
|  | Surveyors:                        |                                |                                     |             |   |         |                  |
|  |                                   | D D                            |                                     |             |   |         |                  |
|  |                                   | RN, BSN, MBA                   |                                     |             |   |         |                  |
|  | Public Health Nurse Surveyor      |                                |                                     |             |   |         |                  |
|  |                                   |                                |                                     |             |   |         |                  |
|  | Jennifer Hembro                   | ee, RN                         |                                     |             |   |         |                  |
|  | Public Health N                   | urse Surveyor                  |                                     |             |   |         |                  |
|  |                                   | ,                              |                                     |             |   |         |                  |
|  | Ken Zeigler                       |                                |                                     |             |   |         |                  |
|  | _                                 |                                |                                     |             |   |         |                  |
|  | Laboratory Surv                   | reyor                          |                                     |             |   |         |                  |
|  |                                   |                                |                                     |             |   |         |                  |
|  | Deborah Franco, RN                |                                |                                     |             |   |         |                  |
|  | Public Health N                   | urse Surveyor                  |                                     |             |   |         |                  |
|  |                                   |                                |                                     |             |   |         |                  |
|  |                                   |                                |                                     |             |   |         |                  |
|  |                                   |                                |                                     |             |   |         |                  |
|  | OA: claughlin 08/                 | 11/11                          |                                     |             |   |         |                  |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any defiency statement ending with an asterisk (\*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

9NC511

Facility ID:

005065

| STATEMENT OF DEFICIENCIES    |   | X1) PROVIDER/SUPPLIER/CLIA   | (X2) MULTIPLE CONSTRUCTION (X3) DATE S |  | E SURVEY  |            |            |
|------------------------------|---|------------------------------|--|--|---|------------|------------|
| AND PLAN OF CORRECTION       |   | II 151306                    |  | DING   | 00  | COMPLETED  |            |
|                              |   |                              |  | B. WING 07/19/   |   |            | 011        |
|                              |   |                              |  |  | ADDRESS, CITY, STATE, ZIP CODE  |            |            |
| NAME OF PROVIDER OR SUPPLIER |   |                              |  | 642 W F  | HOSPITAL RD   |            |            |
|                              | UNIVERSITY HEAI   | LTH PAOLI HOSPITAL           | _                                      | PAOLI,   | IN47454   |            |            |
| (X4) ID                      |   | TATEMENT OF DEFICIENCIES     |  | ID   | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)                                     |            | (X5)       |
| PREFIX                       | •   | CY MUST BE PERCEDED BY FULL  |  | PREFIX   |   |            | COMPLETION |
| TAG                          |   | LSC IDENTIFYING INFORMATION) |  | TAG  | DEFICIENCY)   |            | DATE       |
| S0406                        | 410 IAC 15-1.4-2(   | a)(1)                        |  |  |   |            |            |
|                              | (a) The hospital shall have an effective, organized, hospital-wide, comprehensive quality assessment and improvement program in which all areas of the hospital participate. The program shall be ongoing and have a written plan of implementation that evaluates, but is not limited to, the following: |                              |  |  |   |            |            |
|                              | (1) All services, including services furnished by a contractor.   |                              |  |  |   |            |            |
| •                            |   | ent review and interview,    | S0406                                  | Quality indicators related   | d to  | 08/22/2011 |            |
|                              |   | to include all services,     | 30                                     | 400  | direct services of pediat   |            | 06/22/2011 |
| 1 -                          |   |                              |  |  | cardiac rehabilitation and  |            | 5,         |
|                              |   | provided by a contractor,    |  |  | medication errors have  |            |            |
|                              |   | ality Assurance and          |  |  |   |            |            |
|                              | Performance Imp   | provement (QAPI)             |  |  | been included in the fac  | •          |            |
|                              | program.  |                              |  | QAPI program. Currently cardiac rehabilitation numbers for Indiana University Health Paoli are combined with Bloomington |   |            |            |
|                              | Findings include:  1. Review of facility documents on   |                              |  |  |   |            |            |
|                              |   |                              |  |  | Cardiac Rehab and   | JUII       |            |
|                              |   | vidence that the direct      |  |  | reported on the   |            |            |
|                              | services of pedia   |                              |  |  | •   |            |            |
|                              |   | d medication errors were     |  |  | Bloomington Cardiac   | 1 00       |            |
|                              | included in the fa  | acility QAPI program;        |  |  | Rehabilitation Scorecard as<br>"all sites". A Paoli site<br>specific scorecard is being<br>developed. The following<br>pediatric indicators will be |            |            |
|                              | _   | ts lacked evidence that      |  |  |   |            |            |
|                              | the contracted se   | rvices of bioengineering,    |  |  |   |            |            |
|                              | laboratory and lin  | nen/laundry were             |  |  |   |            |            |
|                              | included in the fa  | acility QAPI program.        |  |  | added to the nursing  |            |            |
|                              | 2. Interview with   | h #S8 on 7-19-11 at 1350     |  |  | scorecard: pediatric fall   |            |            |
|                              | hours confirmed   | the direct services of       |  |  | assessment and weights  |            |            |
|                              | pediatrics, cardia  | c rehabilitation and         |  |  | kilograms. Data collecti  |            |            |
|                              | _   | s are not included in the    |  |  | to start 9/1/2011. The  | OII        |            |
|                              |   |                              |  |  | to Start 9/1/2011. The  |            |            |

## DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

| AND PLAN OF CORRECTION IDENTIFICATION NUMBER: |  | (X2) MULTIPLE CO<br>A. BUILDING   | 00                  | COMPLET   | TED  |                            |
|---|--|---|---------------------|---|--|----------------------------|
|   |  | 151306  | B. WING             |   | 07/19/201  | l1                         |
|   | PROVIDER OR SUPPLIER                   | LTH PAOLI HOSPITAL  | 642 W               | ADDRESS, CITY, STATE, ZIP CODE<br>HOSPITAL RD<br>, IN47454  | ·  |                            |
| (X4) ID<br>PREFIX<br>TAG                      | (EACH DEFICIEN                         | TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION) | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROLIDEFICIENCY)   | BE (   | (X5)<br>COMPLETION<br>DATE |
| IAU   | facility QAPI pro<br>services of bioen | ogram and the contracted gineering, laboratory, y are not included in the         | IAG                 | Nursing OB/Medical Surgical Manager will monitor pediatric indic Cardiac Rehabilitation Manager will monitor cardiac rehabilitation indicators and Pharm Director will monitor medication events. Findings will be collect quarterly and reportet a year to the IU Healt Paoli Quality Council Copy of scorecards submitted.  Reference laboratory service indicator relate timely return of tests been included on the Laboratory Scorecard Laboratory Manager monitors the indicator includes all reference testing sites currently use. Findings have be collected quarterly ar reported twice a year IU Health Paoli Quali Council. Copy of Lab Scorecard submitted.  Orange County Hosp was purchased by | cators, in the lacy cted d twice th lacs d. The r which lace in lace to the ty oratory dital | DATE                       |
|   |  |   |                     | Bloomington Hospital  | 1 11 1   |                            |

## DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

|  | T OF DEFICIENCIES<br>OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 151306                         | (X2) MULTIPLE CC  A. BUILDING  B. WING | 00   | COMPLETED 07/19/2011                                  |
|--|------------------------------------|---|--|--|---|
| NAME OF PROVIDER OR SUPPLIER  INDIANA UNIVERSITY HEALTH PAOLI HOSPITAL |                                    |   | STREET A<br>642 W<br>PAOLI,            | ADDRESS, CITY, STATE, ZIP CODE<br>HOSPITAL RD<br>IN47454   | 1   |
| (X4) ID<br>PREFIX<br>TAG   | (EACH DEFICIEN                     | TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION) | ID<br>PREFIX<br>TAG                    | PROVIDER'S PLAN OF CORRECTION<br>(EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIA<br>DEFICIENCY)   | (X5) COMPLETION DATE                                  |
|  |                                    |   |  | January of 2000. At the time Bioengineering an Laundry/Linen services were provided by Bloomington as part of ownership. An indicator related to Bioengineering has been included on the Maintenance Scorecard and an indicator related laundry and linen service has been added to the Housekeeping Scorecard Maintenance and Housekeeping Managerespectively, will monitor indicators, collect finding quarterly and report twice year to the IU Health Paguality Council. Copies scorecards submitted.  Completed: August 22 2011 | the or ng he d to ce ard.  ers, or ags ce a aoli s of |

| STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  151306        |   | (X2) M<br>A. BUII<br>B. WIN  | LDING  | NSTRUCTION  00 | (X3) DATE S<br>COMPL<br><b>07/19/2</b>   | ETED                    |            |
|---|---|--|--------|----------------|--|-------------------------|------------|
| NAME OF PROVIDER OR SUPPLIER  INDIANA UNIVERSITY HEALTH PAOLI HOSPITAL  (X4) ID SUMMARY STATEMENT OF DEFICIENCIES |   |  | p. why | STREET A       | DDRESS, CITY, STATE, ZIP CODE HOSPITAL RD IN47454  PROVIDER'S PLAN OF CORRECTION   |                         | (X5)       |
| PREFIX  | (EACH DEFICIENCY MUST BE PERCEDED BY FULL<br>REGULATORY OR LSC IDENTIFYING INFORMATION)   |  |        | PREFIX         | (EACH CORRECTIVE ACTION SHOULD BE<br>CROSS-REFERENCED TO THE APPROPRIAT  | ΓE                      | COMPLETION |
| TAG   |   |  |        | TAG            | DEFICIENCY)  |                         | DATE       |
| S1164   | follows: (2) There shall be equipment and sp safe, effective, and of the available se as follows:  (B) There shall be preventive maintenequipment.  Based on observe and interview, the provide evidence maintenance on endoscopy proces. Services Department.  Findings include  1. During tour of area on 7/19/201 in the presence of Olympus OER P was observed in  2. Review of the guidelines for the endoscopy proces recommendation monthly schedule equipment. This | sufficient acce to assure the difficient acce to assure the difficient acce to assure the difficient provision rices to patients,  a evidence of hance on all action, document review a facility failed to a of preventative and of 1 Olympus OER Prossors in the Surgical hent.  d:  f the surgical services and beginning at 10:00 AM and P16, one are endoscopy processor the processing room.  It manufacturer's a olympus OER Prossor revealed as for daily, weekly, and and maintenance of the scheduled maintenance of the scheduled maintenance of the gas | S1     | 164            | The daily, weekly, and monthly scheduled maintenance of the Olympus OER-Pro endoscopy processor w reviewed by the Surgery Manager and surgery st in discussion with the Olympus representative August 17, 2011.  Review of Reuse Lives the OER-Pro filters indicated a specific replacement schedule for the Air Filter every 30 dalt was noted whenever to Vapor Filter efficacy is obviously decreased or, the case of the Water Filter every 6 months or more frequently depending or water quality. Copy of submitted. Since the | of or ays. he in alter, | 08/29/2011 |

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| AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  151306                 |   | (X2) MULTIPLE C  A. BUILDING  B. WING   | 00                  | COMPL<br>07/19/2   | ETED  |                            |
|---|---|---|---------------------|--|---|----------------------------|
| NAME OF PROVIDER OR SUPPLIER INDIANA UNIVERSITY HEALTH PAOLI HOSPITAL |   |   | STREET<br>642 W     | CADDRESS, CITY, STATE, ZIP CODI<br>V HOSPITAL RD<br>I, IN47454   | E   |                            |
| (X4) ID<br>PREFIX<br>TAG  | (EACH DEFICIEN  | TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)                                     | ID<br>PREFIX<br>TAG | PROVIDER'S PLAN OF CORREC<br>(EACH CORRECTIVE ACTION SHOU<br>CROSS-REFERENCED TO THE APPF<br>DEFICIENCY)   | LD BE<br>ROPRIATE   | (X5)<br>COMPLETION<br>DATE |
|   | 7/19/2011 beginn<br>P16 indicated that<br>testing, no other | iew with P1 and P16 on ning at 10:00AM, P1 and at apart from the daily preventative maintenance ned on the equipment. |                     | efficacy and water of cannot be confirmed satisfaction IU Health has chosen to replate gas, air and water fithe minimum time in of monthly. The Sur Manager will monitor changing schedule report twice a year of Policy and Filter Changle Log submitted.  Completed: August 2011 | th Paoli<br>ce the<br>lters at<br>nterval<br>rgery<br>or the<br>and<br>to the<br>ange |                            |